

Maternal Deaths in the United States

Understanding the Data and Moving Forward

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Governor's Taskforce on Maternal Mortality and Disparate Racial Outcomes
New York State Department of Health
June 27, 2018



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

Presenter Disclosures

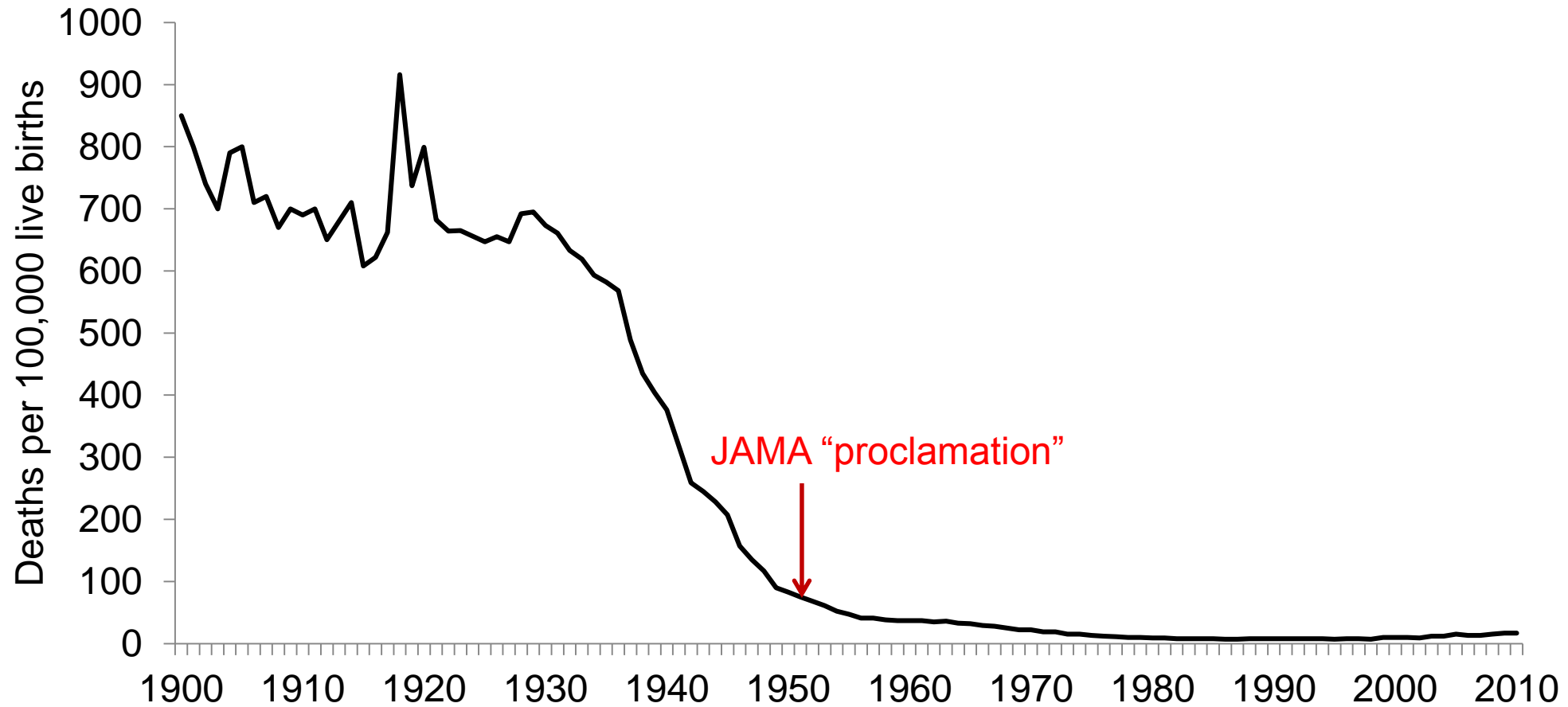
- No financial disclosures
- The findings and conclusions in this report are those of the author and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

MATERNAL DEATHS—ONE IN A THOUSAND

THE JOURNAL takes pride in announcing that for the first time in history the maternal mortality rate for a large nation—the United States of America—has been pushed slightly below the apparently irreducible minimum of 1 maternal death per 1,000 live births. When

This is, indeed, a story of human as well as medical progress. The fact that the chances of survival for the mother are better than 999 out of 1,000 should bring comfort and consolation in a troubled era to expectant mothers and their husbands, their children and their parents. Childbearing has been made quite safe.

Maternal Mortality Rate, United States





LOST MOTHERS



How Many American Women Die From Causes Related to Pregnancy or Childbirth? No One Knows.



Data collection on maternal deaths is so flawed and under-funded that the federal government no longer even publishes an official death rate.

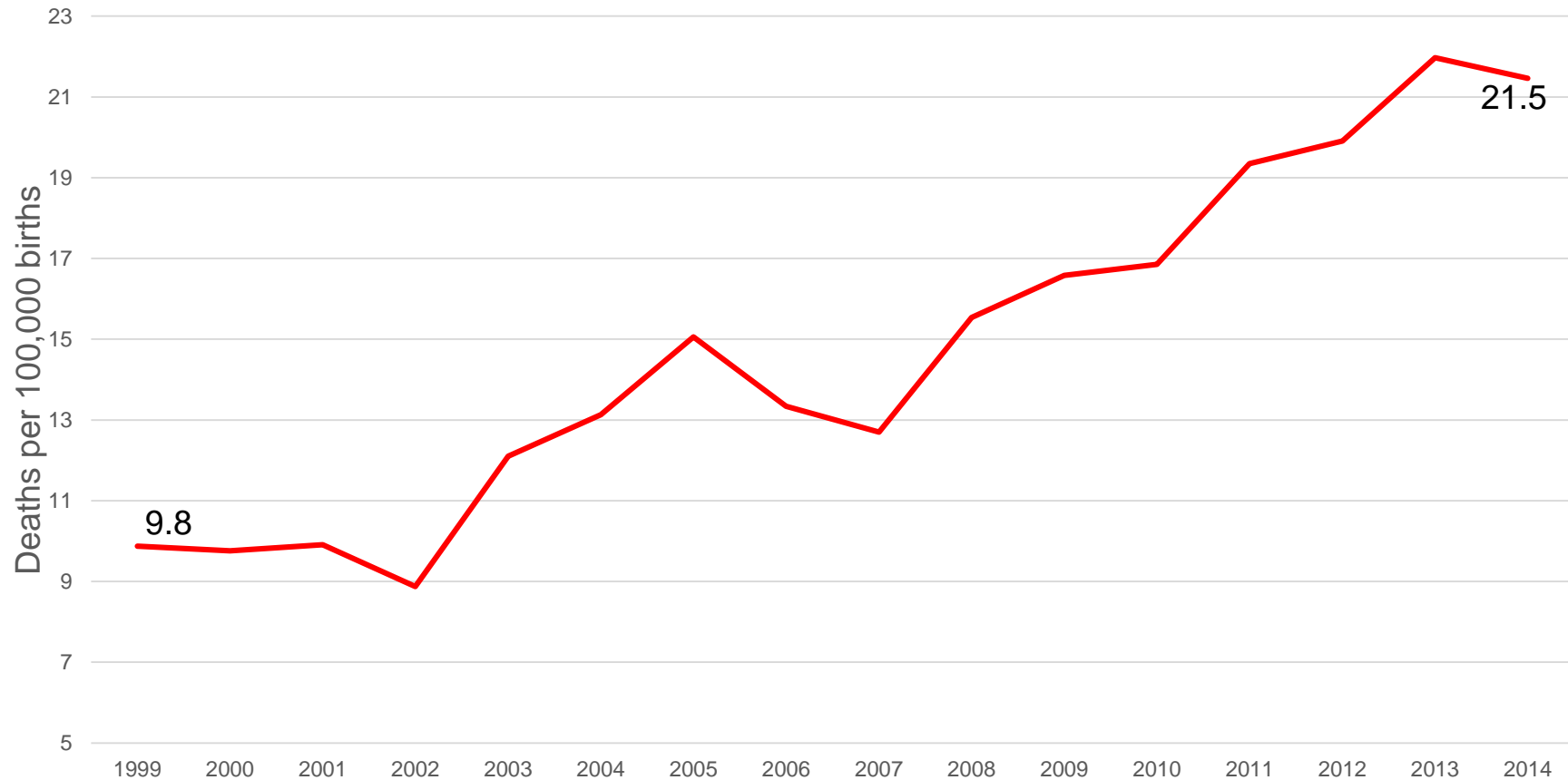
by **Robin Fields** and **Joe Sexton**, Oct. 23, 8 a.m. EDT

Why America's Black Mothers and Babies Are in a Life-or-Death Crisis

The answer to the disparity in death rates has everything to do with the lived experience of being a black woman in America.

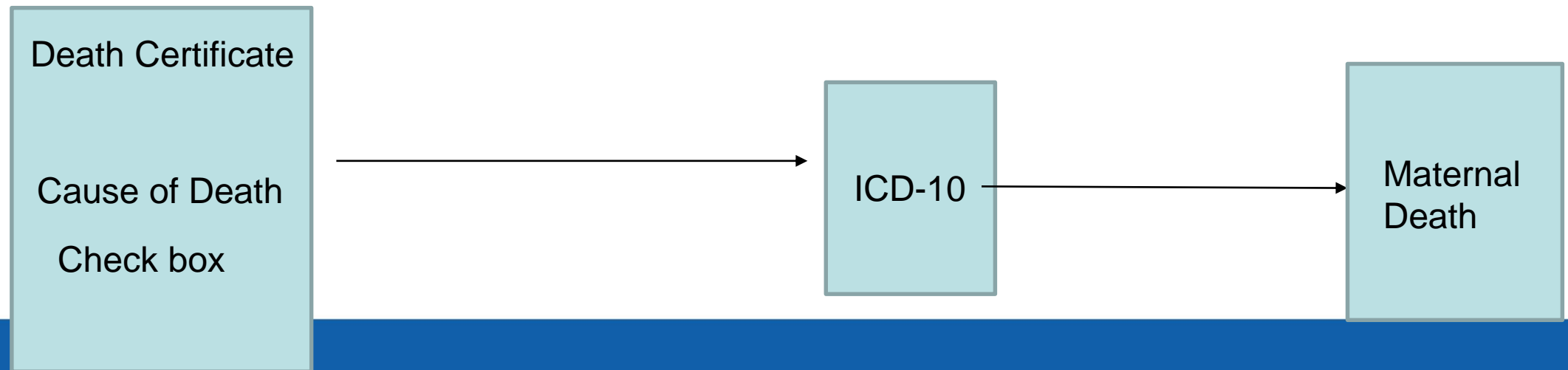
By LINDA VILLAROSA APRIL 11, 2018

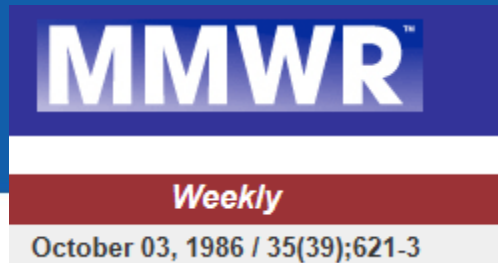
Maternal Mortality Rate, 1999-2014



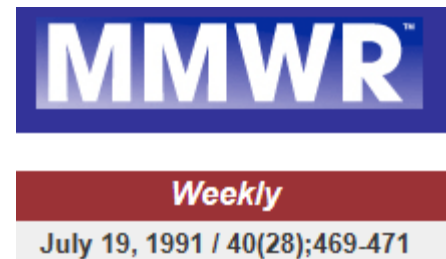
Maternal Mortality: Vital Statistics

Maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.





Misclassification of Maternal Deaths -- Washington State



Perspectives in Disease Prevention and Health Promotion Enhanced Maternal Mortality Surveillance -- North Carolina, 1988 and 1989



February 10, 1995 / Vol. 44 / No. 5



- 81 Update: AIDS Among Women — United States, 1994
- 84 Update: Influenza Activity — United States, 1994–95 Season
- 86 Human Rabies — West Virginia, 1994
- 93 Pregnancy-Related Mortality — Georgia, 1990–1992
- 96 Notice to Readers
- 99 Monthly Immunization Table

Pregnancy-Related Mortality — Georgia, 1990–1992

Underreporting of Pregnancy-Related Mortality in the United States and Europe

Catherine Deneux-Tharaux, MD, MPH, Cynthia Berg, MD, MPH, Marie-Helene Bouvier-Colle, PhD, Mika Gissler, PhD, Margaret Harper, MD, PhD, Angela Nannini, FNP, PhD, Sophie Alexander, MD, PhD, Katherine Wildman, PhD, Gerard Breart, MD, and Pierre Buekens, MD, PhD

Obstet Gynecol 2005;106:684-92

The Check Box

Am J Prev Med 2000;19:35-
39

Determining Pregnancy Status to Improve Maternal Mortality Surveillance

Andrea P. MacKay, MSPH, Roger Rochat, MD, Jack C. Smith, MS, Cynthia J. Berg, MD, MPH

Vital statistics, 1991-1992

Checkbox is a simple and effective way of identifying maternal deaths

Regular use by all states would enhance surveillance

2003 and beyond: Pregnancy checkbox

LOCAL FILE NO. m826				U.S. STANDARD CERTIFICATE OF DEATH				STATE FILE NO. 941							
1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last)						2. SEX		3. SOCIAL SECURITY NUMBER							
4a. AGE-Last Birthday (Years)		4b. UNDER 1 YEAR		4c. UNDER 1 DAY		5. DATE OF BIRTH (Mo/Day/Yr)		6. BIRTHPLACE (City and State or Foreign Country)							
		Months		Days		Hours		Minutes							
7a. RESIDENCE-STATE						7b. COUNTY				7c. CITY OR TOWN					

36. IF FEMALE:

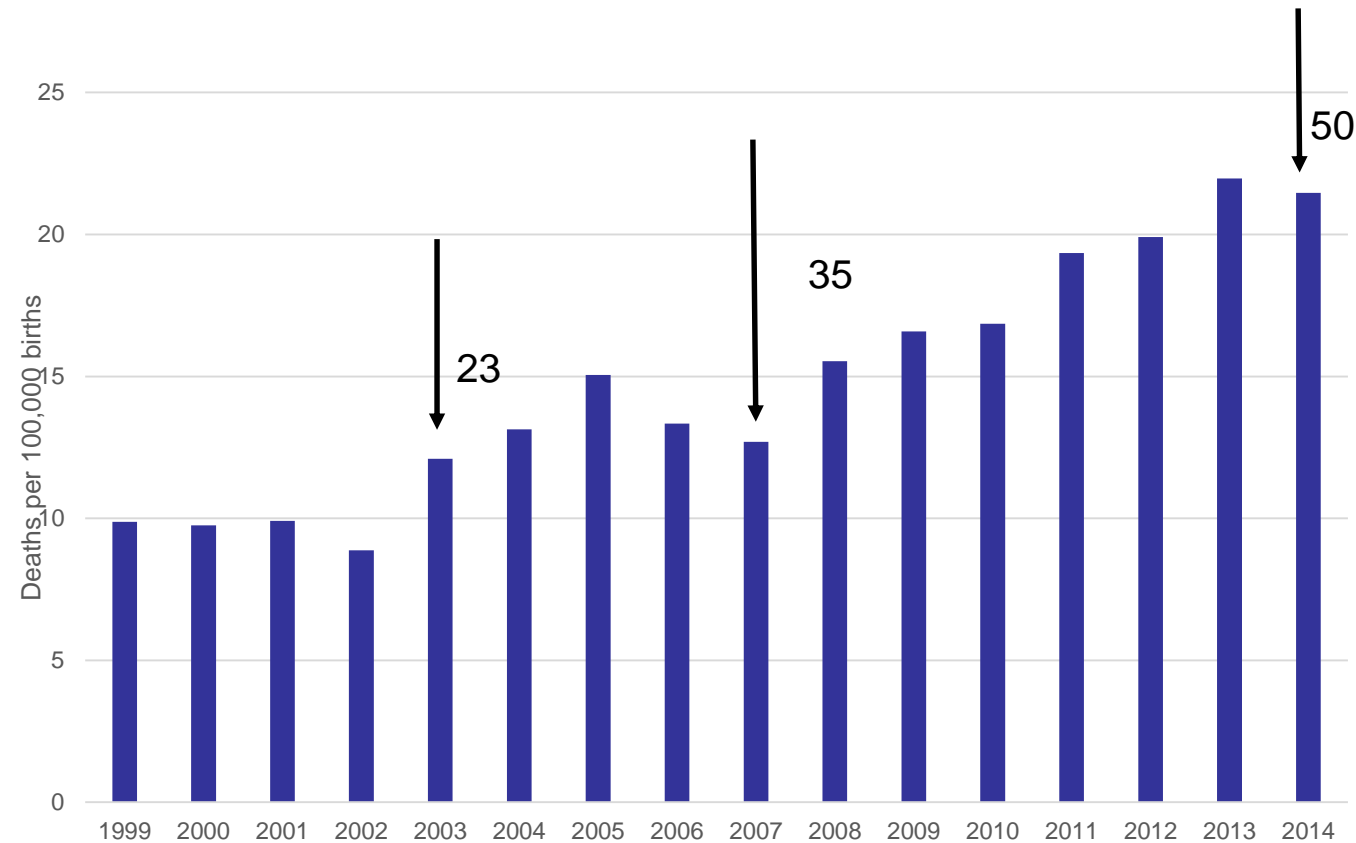
- ☐ Not pregnant within past year
- ☐ Pregnant at time of death
- ☐ Not pregnant, but pregnant within 42 days of death
- ☐ Not pregnant, but pregnant 43 days to 1 year before death
- ☐ Unknown if pregnant within the past year

2003: 21 states with checkbox; 2 states with prompt

2005: 35 states with checkbox or prompt

2015: 46 states and DC with standard checkbox; 3 states non-standard checkbox

Maternal Mortality Rate, 1999-2014



Original Research

Identifying Maternal Deaths in Texas Using an Enhanced Method, 2012

*Sonia Baeva, MA, Debra L. Saxton, MS, Karen Ruggiero, PhD, Michelle L. Kormondy, BS,
Lisa M. Hollier, MD, MPH, John Hellerstedt, MD, Manda Hall, MD, and Natalie P. Archer, PhD*

Obstet Gynecol 2018;131:762-9

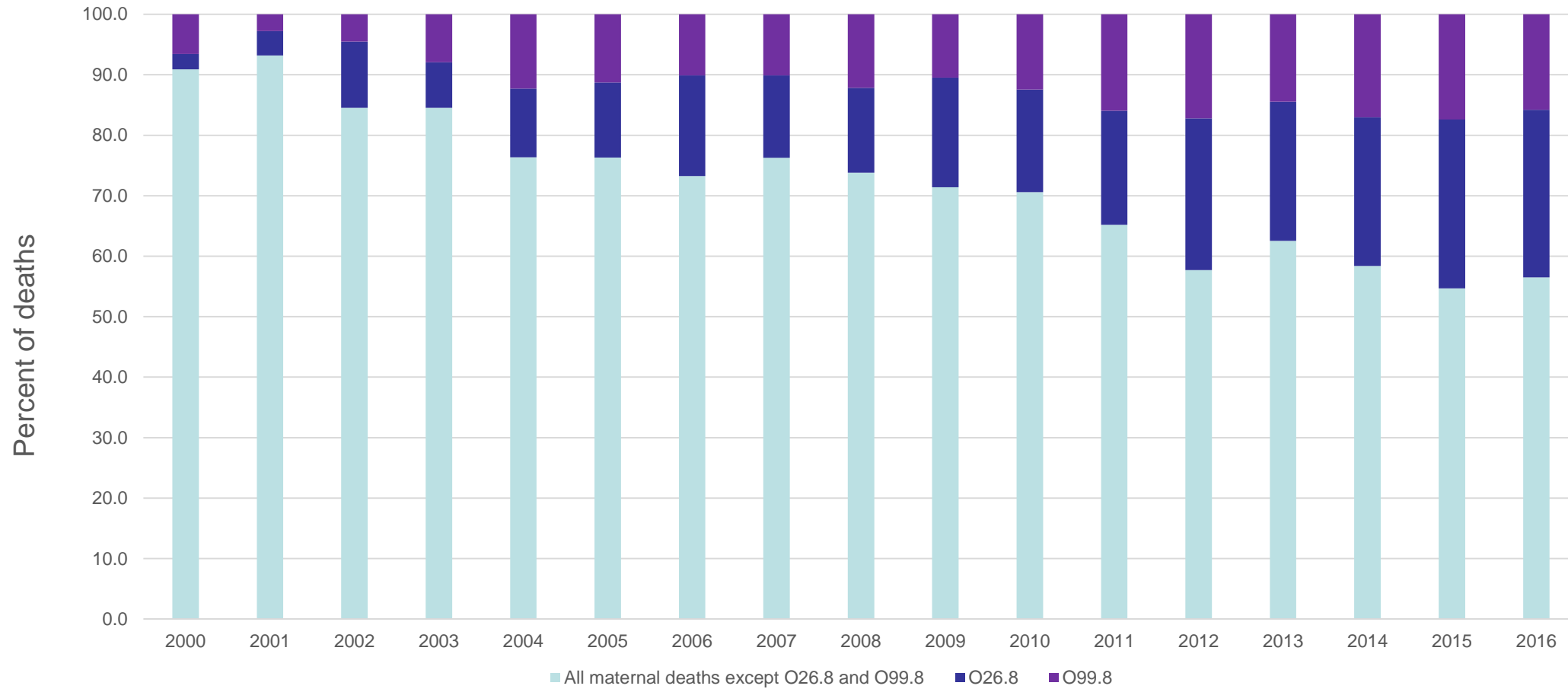
Half of deaths coded as maternal showed no evidence of pregnancy upon review.

Editorial

Making Vital Statistics Count: Preventing U.S. Maternal Deaths Requires Better Data

MacDorman et al. Obstet Gynecol 2018;131:759-61

Distribution of ICD-10 O chapter codes recorded as underlying cause-of-death, 2000-2016



O 26.8:Other specified pregnancy related conditions

O 99.8:Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium

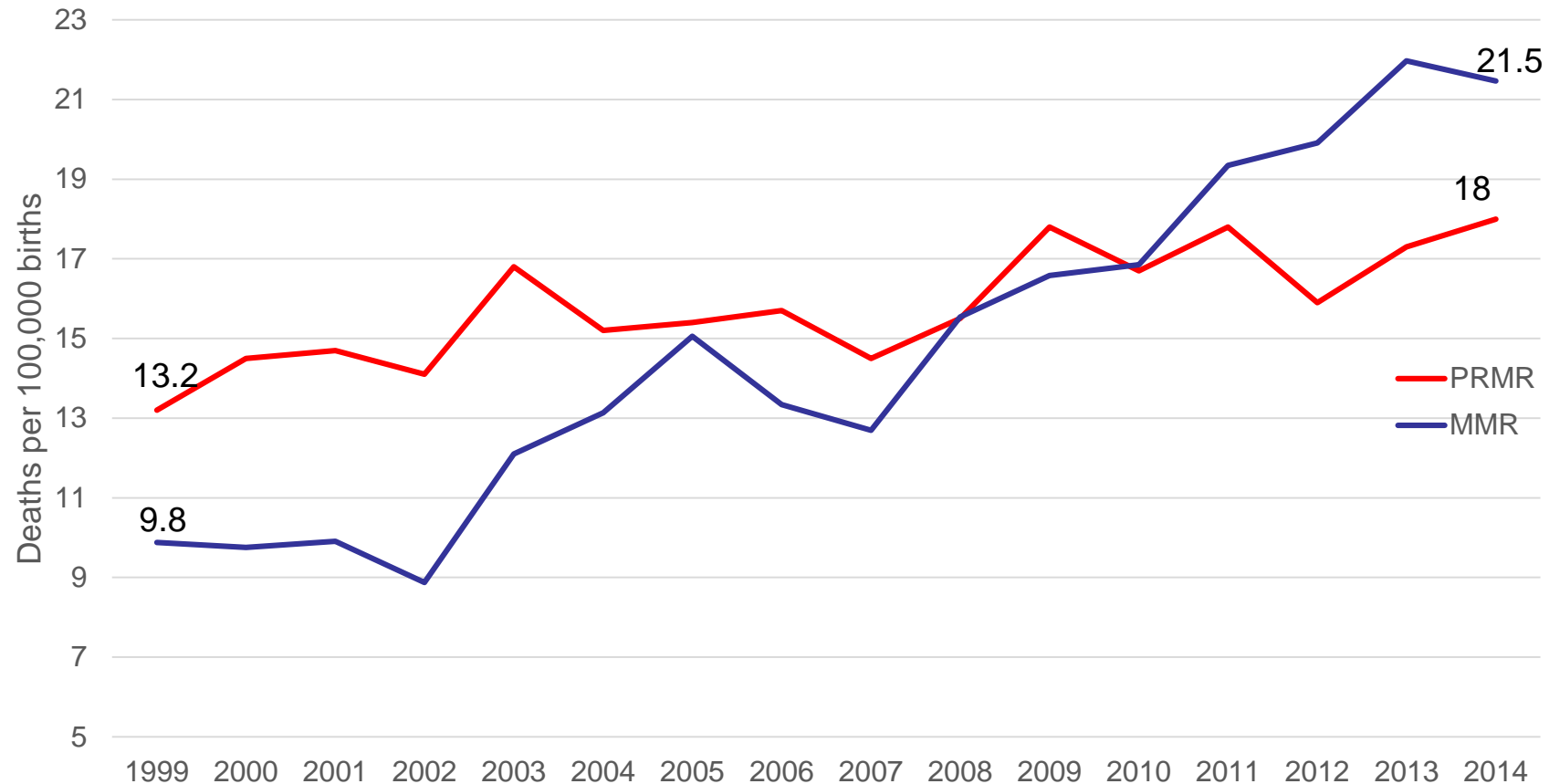
Pregnancy Mortality Surveillance System (PMSS)

- **ACOG/CDC Maternal Mortality Study Group (1986)**
- **Pregnancy-associated (temporal relationship)**
 - All deaths during pregnancy and within the year following the end of pregnancy
- **Pregnancy-related (subset of pregnancy-associated; causal relationship)**
 - Complication of pregnancy
 - Aggravation of a unrelated condition by the physiology of pregnancy
 - Chain of events initiated by the pregnancy
- **Pregnancy-related mortality ratio (PRMR; deaths per 100,000 births)**

PMSS: Enhanced Surveillance

- **Based on death and linked birth or fetal death certificates when death occurred following birth or stillbirth**
- **Independent of ICD-10**
- **Information includes COD and checkbox indicating recent or current pregnancy status and all other details concerning pregnancy**
 - COD descriptions often unclear
 - If checkbox only and unclear COD, difficult to include or exclude
- **Clinical relevance instead of rule-based designation of COD**

Comparison: MMR and PRMR

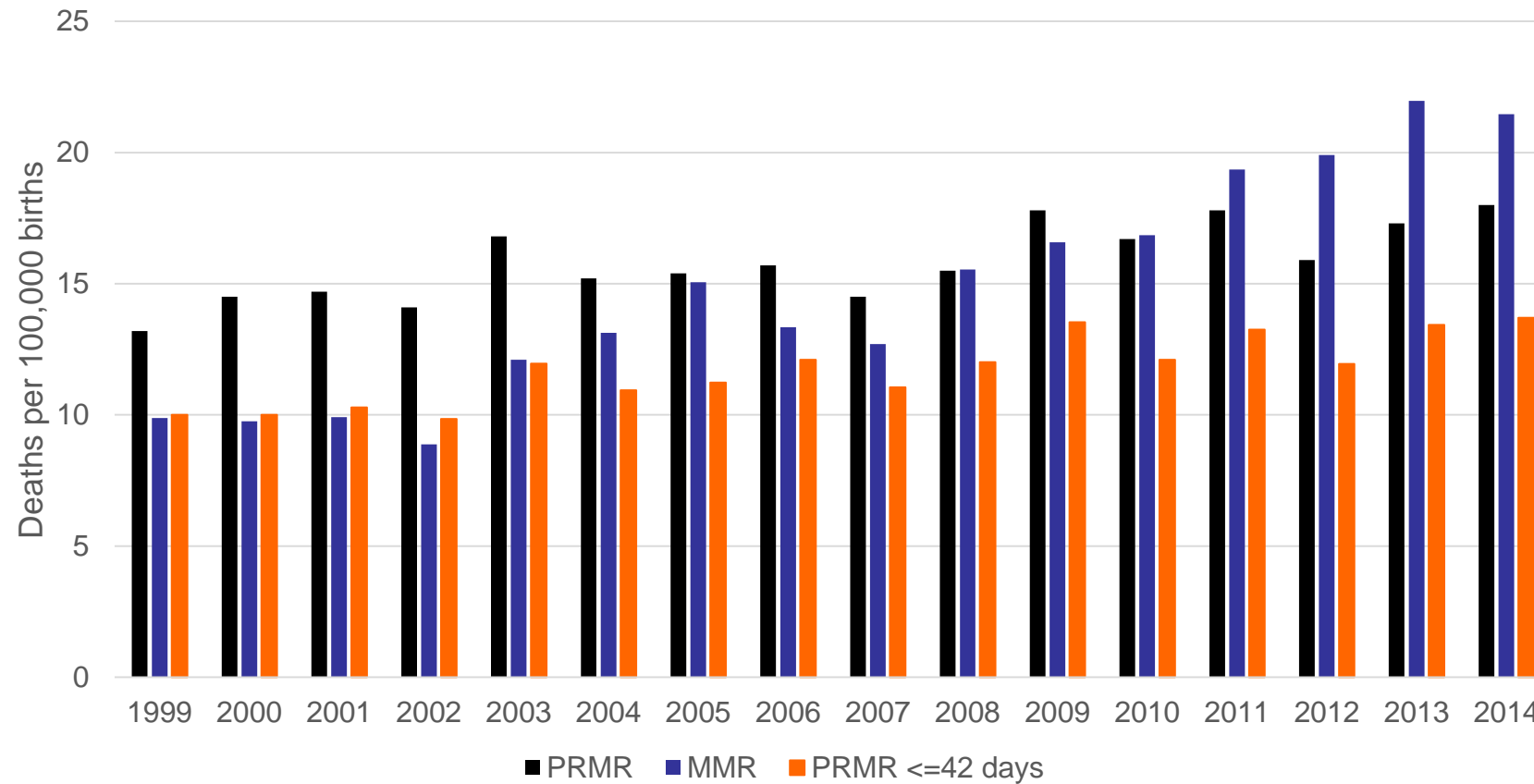


Pregnancy Mortality Surveillance System <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html>

PRMR: Pregnancy-related mortality ratio

MMR: Maternal Mortality rate

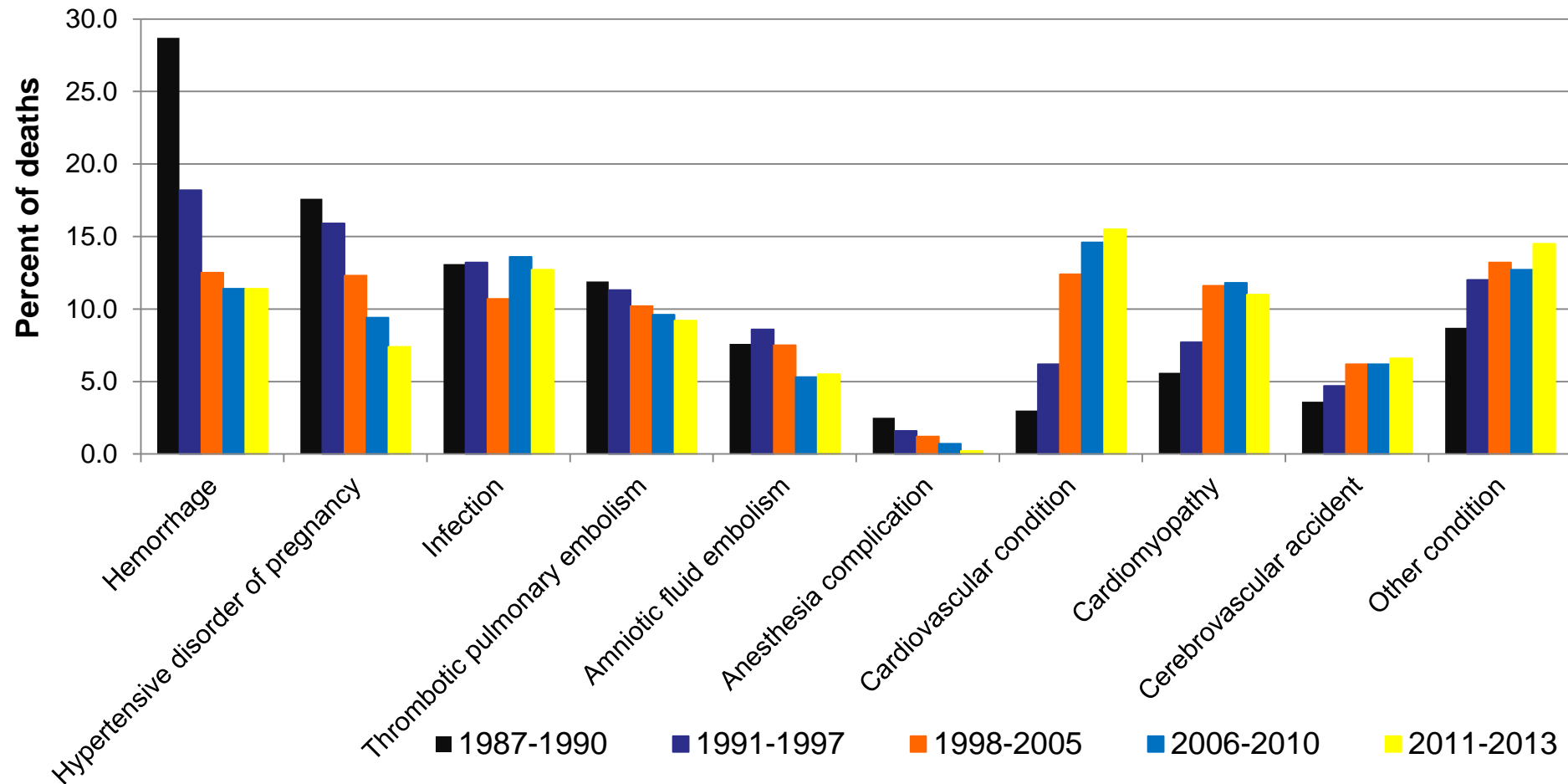
Comparison: MMR and PRMR



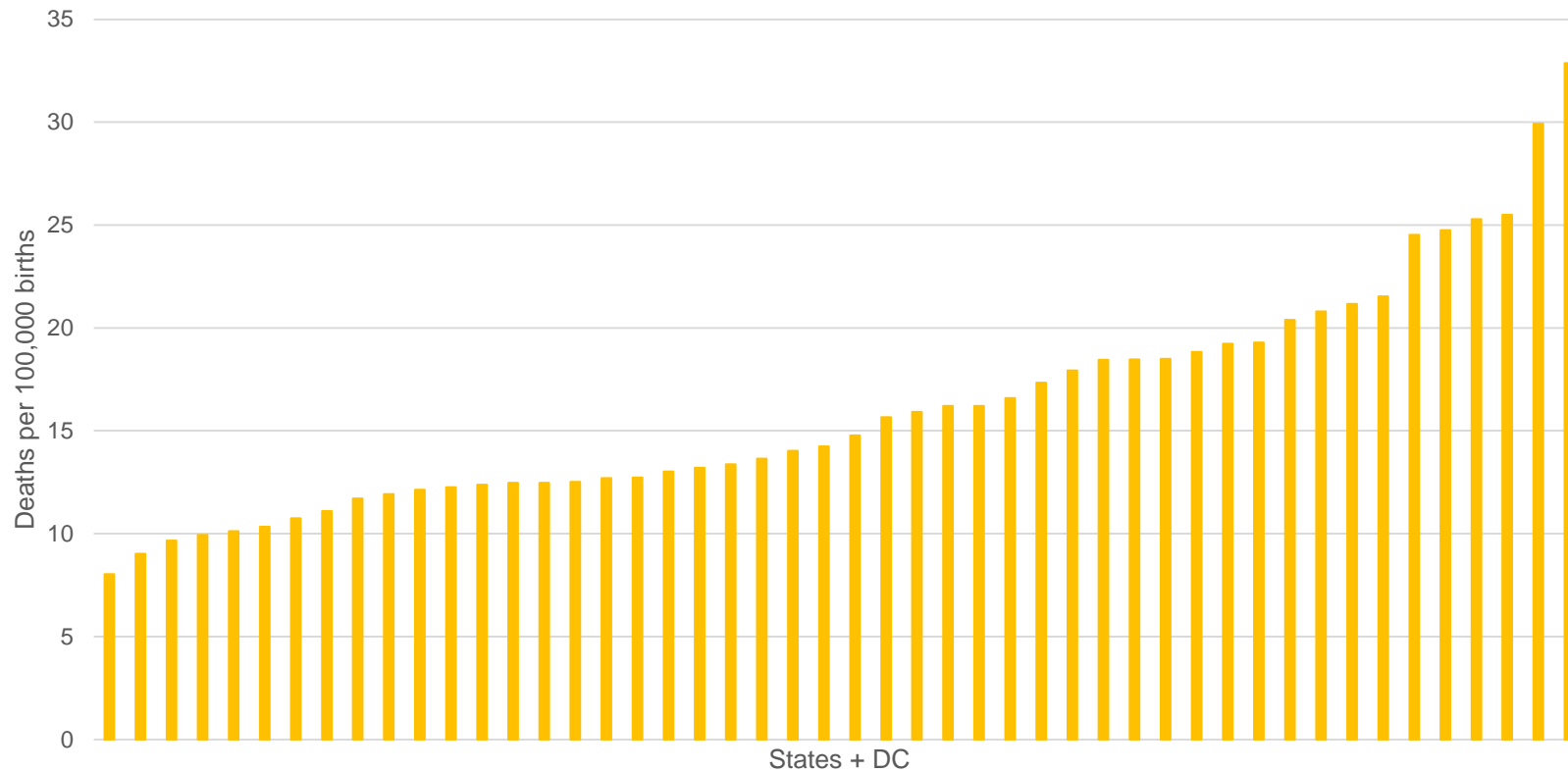
PRMR: Pregnancy-related mortality ratio

MMR: maternal mortality rate

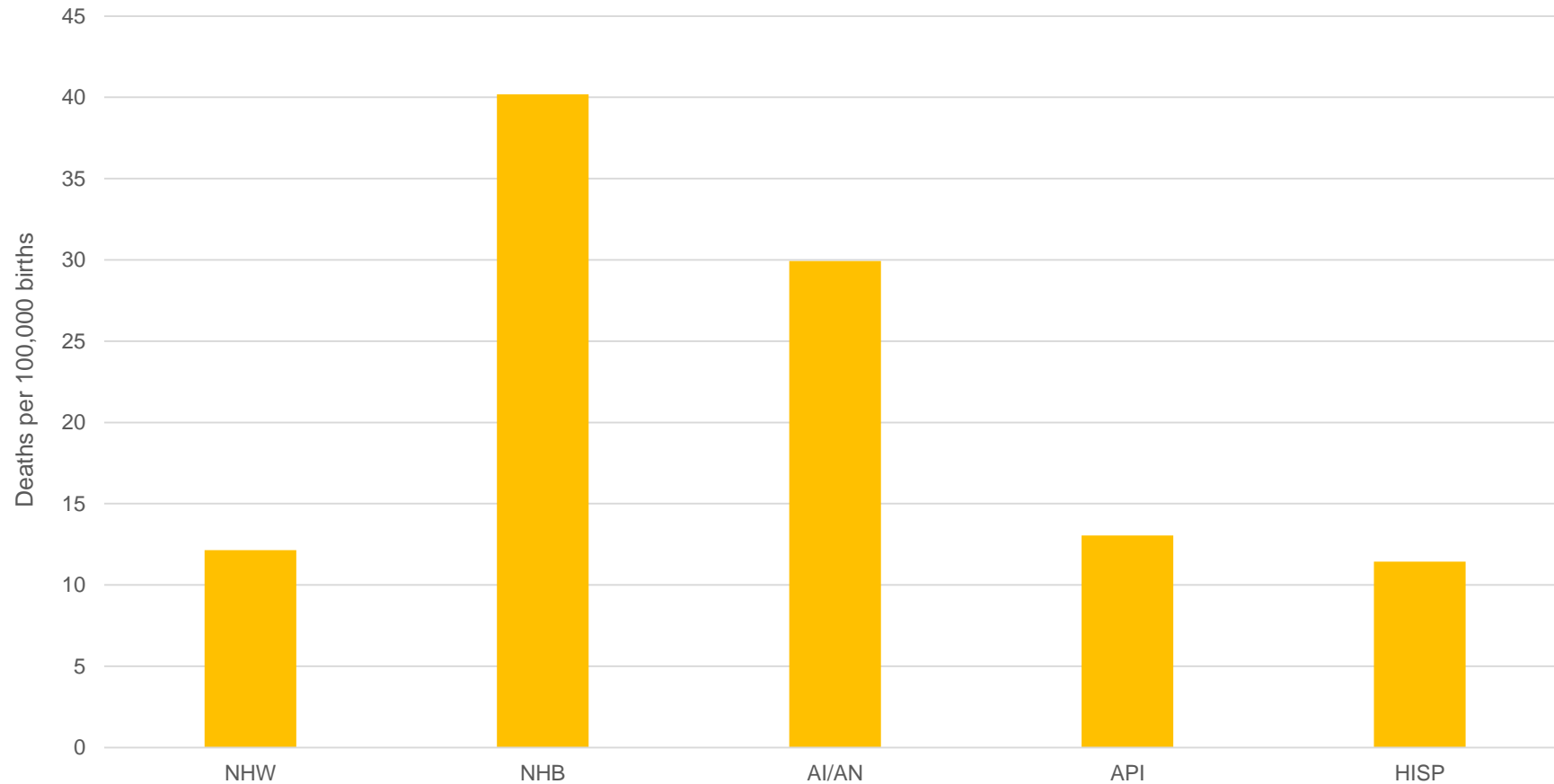
Cause-specific proportionate pregnancy-related mortality, PMSS, 1987-2013



Pregnancy-related Mortality Ratios by State, PMSS, 2006-2013



Pregnancy-related Mortality by Race and Hispanic Ethnicity, 2006-2013

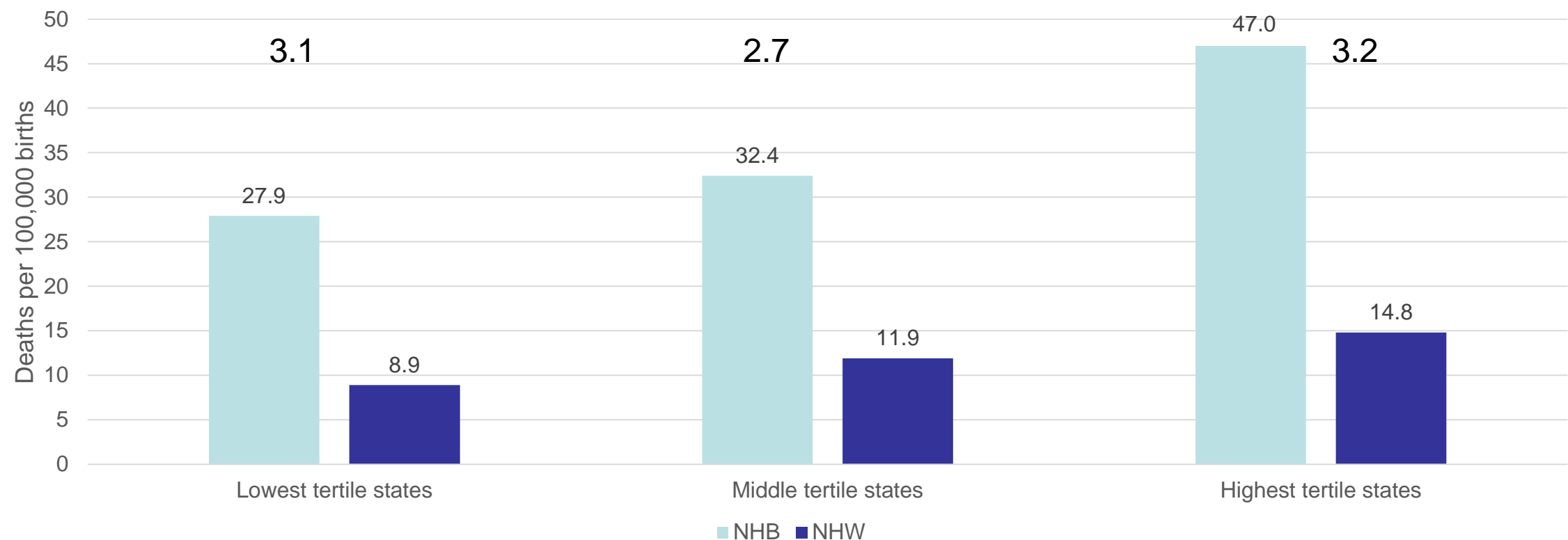


NHW: Non-Hispanic white
API: Asian/Pacific Islander

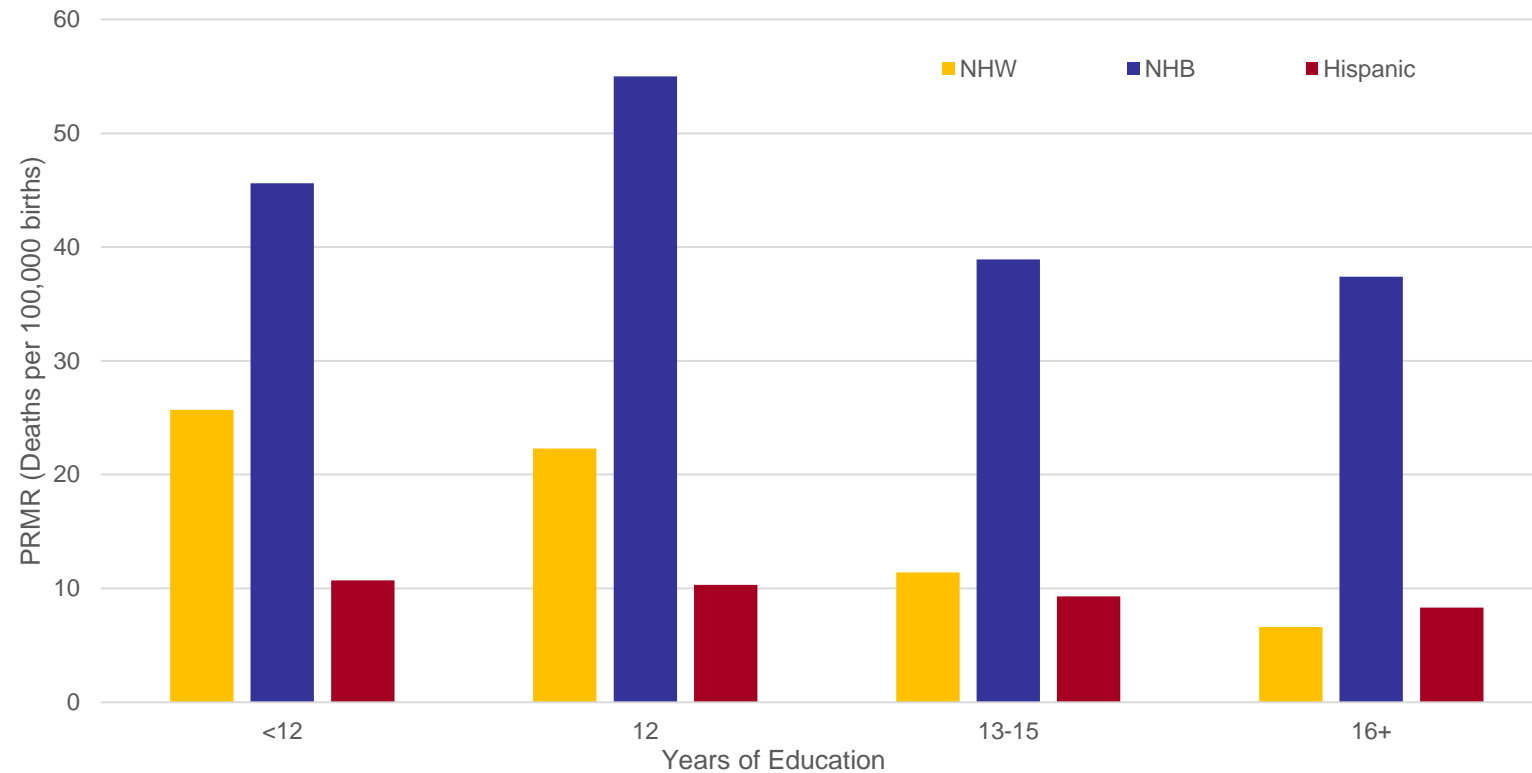
NHB: Non-Hispanic black

AI/AN: American Indian/Alaska Native

Black: White Pregnancy-related Mortality Ratios, PMSS, 2006-2013



PRMR by Race/Ethnicity and Education



What Are the Real Trends in Maternal Mortality?

- The *measured* maternal mortality rate is increasing
- The pregnancy-related mortality rate has increased but is now relatively stable
- Disparities are persistent, and some causes of death may be increasing
- There are hints that efforts to improve identification have resulted in misclassification
 - What is the extent of the false positives?
 - What is the extent of the false negatives?
 - Why are mistakes being made?

Beyond Better Data

- **We need to aspire to something greater**
 - Information needed for prevention will not be found on death certificates
- **There is no acceptable rate of maternal mortality**



Strategies to Reduce Pregnancy-Related Deaths

From Identification and Review to Action

2001



State Maternal Mortality Review

Accomplishments of Nine States

2006



Invitational Meeting on State Maternal Mortality Review September 2003

In September 2003, the Safe Motherhood Partnership* and the American College of Obstetricians and Gynecologists sponsored a 2-day meeting for nine states with active maternal mortality review committees. We would like to thank the people who participated in this meeting for their contributions to this publication and for their ongoing efforts to improve women's health before, during, and after pregnancy.

State Representatives

Florida

Carol Graham, PhD
Annette Phelps, ARNP

Massachusetts

Linda Clayton, MD, MPH
Angela Nannini, FNP, PhD

Michigan

James Gell, MD
Joanne Hogan, PhD

New Jersey

Elizabeth Ferraro, RN, MSN, APNC
James Thompson, MD

New Mexico

Margaret Wolak, MD
Anne Worthington, MPH

New York

Mary Applegate, MD
Jeffrey King, MD, FACOG

North Carolina

Margaret Harper, MD, MS

Utah

Lois Bloebaum, BSN
Michael Varner, MD

Virginia

Cheryl Bodamer, RN, MPH

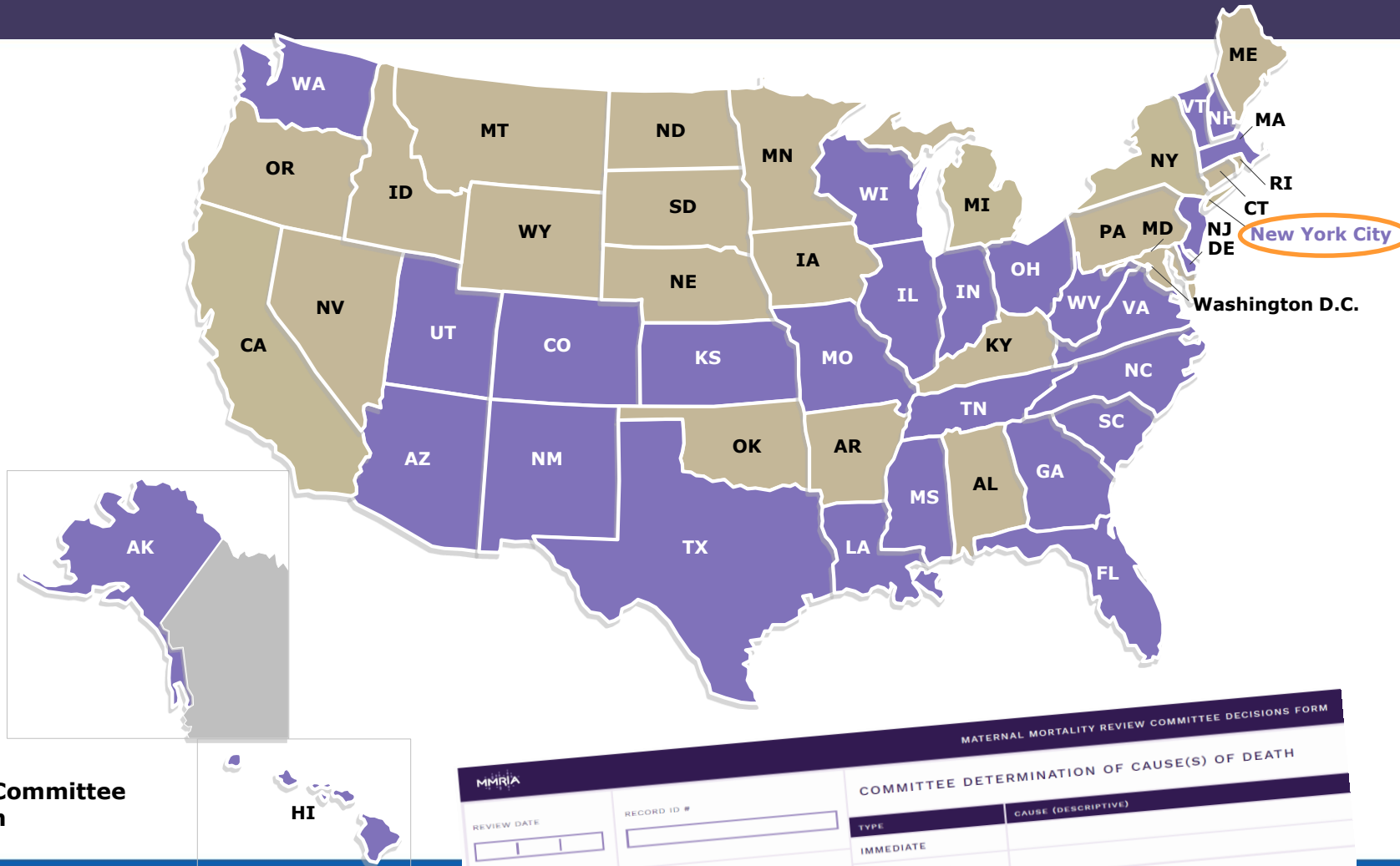
Building U.S. Capacity to Review and Prevent Maternal Deaths

- **Technical assistance to support jurisdiction-level maternal mortality review**
- **Promotes opportunities to identify interventions with the greatest potential to end preventable maternal mortality**
- **Partnership of CDC Division of Reproductive Health, the Association of Maternal and Child Health Programs, and the CDC Foundation (funded through an award agreement with Merck on behalf of its Merck for Mothers program)**



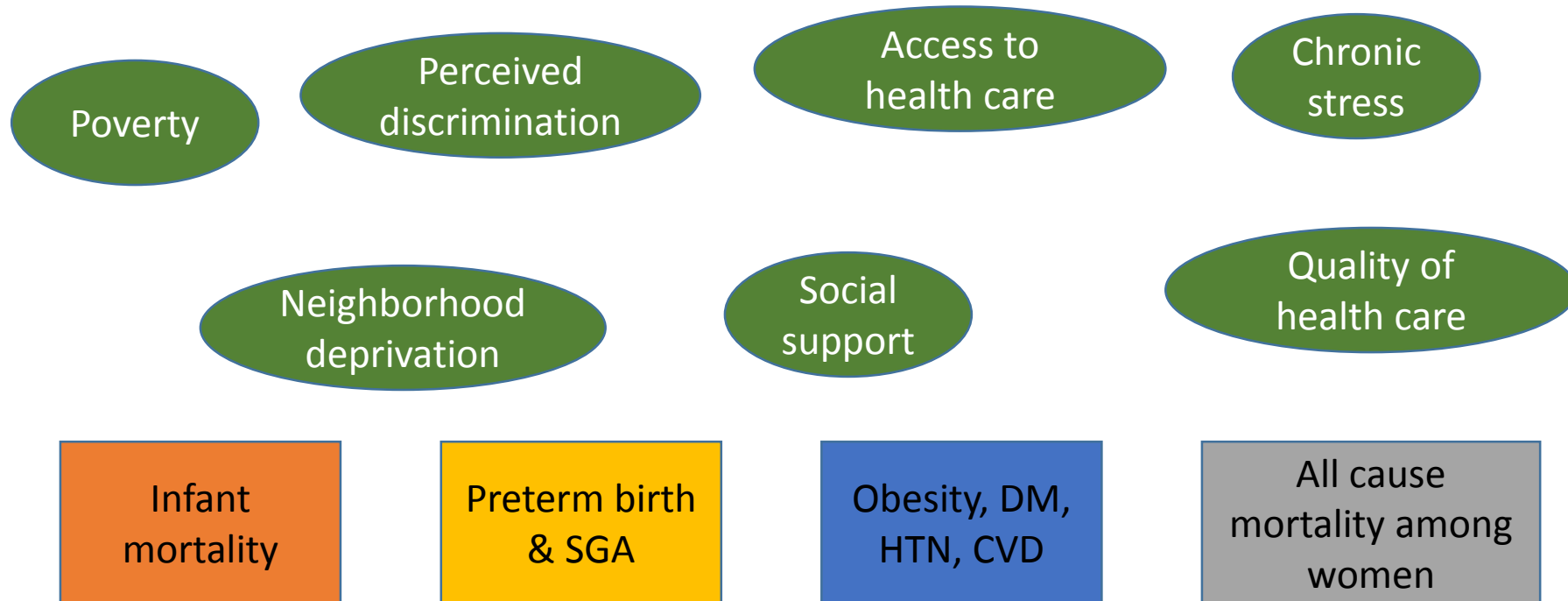
Resources: Maternal Mortality Review Information Application (MMRIA)

- **Addresses barrier identified by MMRCs (2012)**
- **Built with expert input**
- **Lessons learned from precursor (2014-2016)**
- **One stop shop**
- **Comprehensive, but standardized**
- **Common language for reviews to work together**
- **22 jurisdictions using MMRIA, 7 preparing to use (but are using the committee decisions form), 5 on the wait list**



MMRIA				MATERNAL MORTALITY REVIEW COMMITTEE DECISIONS FORM											
REVIEW DATE		RECORD ID #		COMMITTEE DETERMINATION OF CAUSE(S) OF DEATH											
<div> <div></div> <div></div> <div></div> </div>		<div></div>		<table border="1"> <thead> <tr> <th>TYPE</th> <th>CAUSE (DESCRIPTIVE)</th> </tr> </thead> <tbody> <tr> <td>IMMEDIATE</td> <td></td> </tr> <tr> <td>CONTRIBUTING</td> <td></td> </tr> <tr> <td>UNDERLYING</td> <td></td> </tr> <tr> <td>OTHER SIGNIFICANT</td> <td></td> </tr> </tbody> </table>		TYPE	CAUSE (DESCRIPTIVE)	IMMEDIATE		CONTRIBUTING		UNDERLYING		OTHER SIGNIFICANT	
TYPE	CAUSE (DESCRIPTIVE)														
IMMEDIATE															
CONTRIBUTING															
UNDERLYING															
OTHER SIGNIFICANT															
PREGNANCY-RELATEDNESS: SELECT ONE				COMMITTEE DETERMINATION OF UNDERLYING CAUSE OF DEATH											
<input type="checkbox"/> PREGNANCY-RELATED The death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by the physiologic effects of pregnancy				IF PREGNANCY-RELATED, COMMITTEE DETERMINATION OF UNDERLYING CAUSE OF DEATH. Refer to attached page for PMSS-MM cause of death list. If more than one is selected, list in order of importance beginning with the most compelling (1-2; no more than 2 may be selected in the system)											
<input type="checkbox"/> PREGNANCY-ASSOCIATED, BUT NOT -RELATED The death of a woman during pregnancy or within one year of the end of pregnancy from a cause that is not related to pregnancy.															

Social determinants of women's morbidity & mortality?



From Michael Kramer (Emory)

Maternal Mortality Review Committees have access to multiple sources of information that provide a deeper *understanding of the circumstances* surrounding a woman's death. With these insights review committees *develop actionable recommendations to prevent future deaths.*

Place-based data: abstractor view

Place of Last Residence

Street

4770 Buford Hwy

Apartment or Unit Number

City

State*

GA- Georgia

Zip Code

30341

County

Fulton

GET COORDINATES

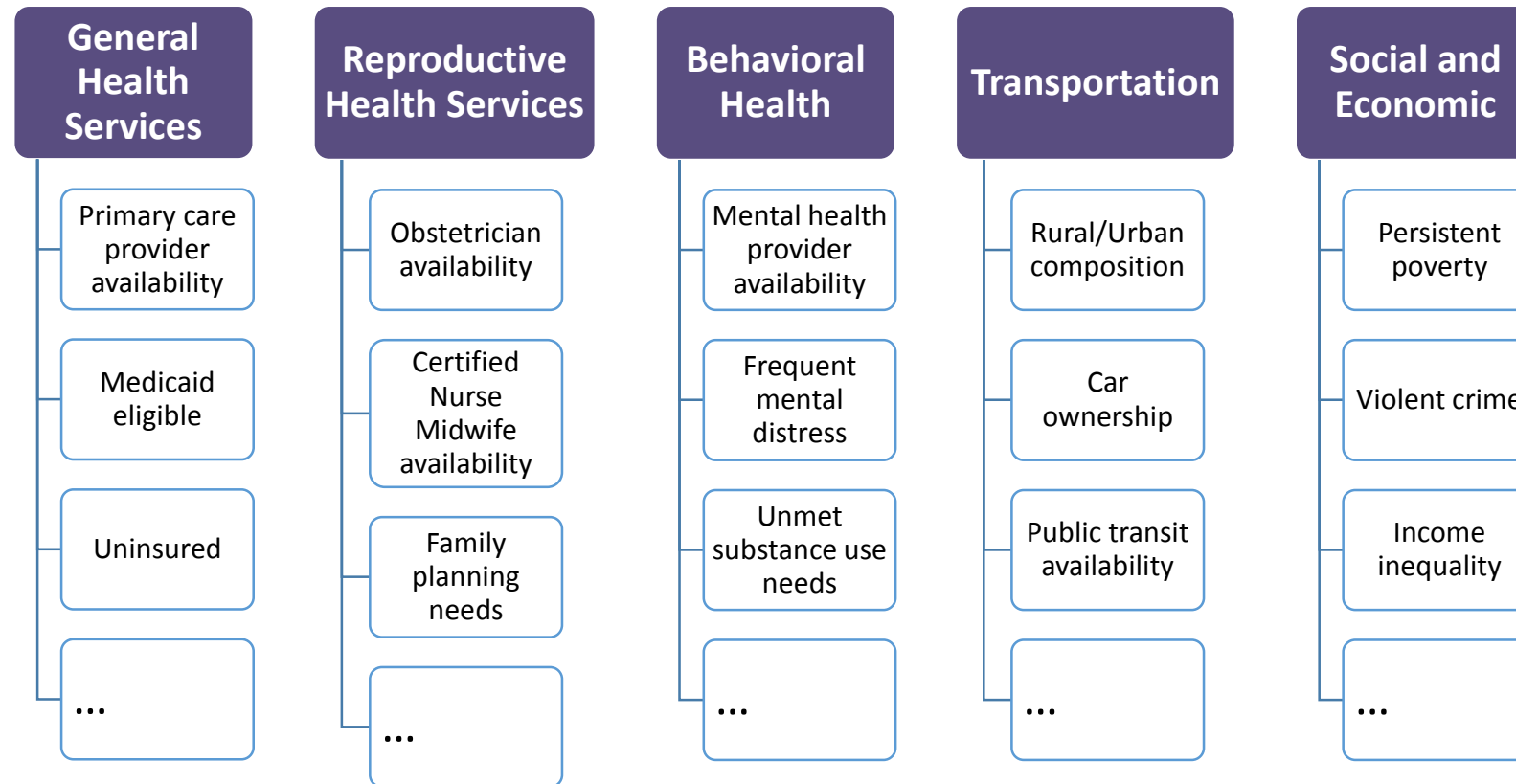
Latitude

33.8806784345453

Longitude

-84.2911002631521

5 domains with examples of indicators



Adapted from: Report from Nine Maternal Mortality Review Committees. <http://www.reviewtoaction.org/rsc-ra/term/70>

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REVIEW TO ACTION
PROMOTES THE MATERNAL
MORTALITY REVIEW
PROCESS AS THE BEST
WAY TO UNDERSTAND
WHY MATERNAL
MORTALITY IN THE UNITED
STATES IS INCREASING
AND PRIORITIZE
INTERVENTIONS TO
IMPROVE MATERNAL
HEALTH.

ALLIANCE FOR INNOVATION ON MATERNAL HEALTH PROGRAM

[Home](#) // Alliance for Innovation on Maternal Health Program

AIM Logo_Latest



ALLIANCE FOR INNOVATION
ON MATERNAL HEALTH **AIM**



New York State OB Hemorrhage Project

- Recruitment Package
- Hospital Participants (password protected)

OB Prenatal Education
Project Table of Contents:

➔ [NYSPQC Homepage](#)

Hypertensive Disorders in Pregnancy Resources

- **NYS received an award from CDC to support their Perinatal Quality Collaborative**

Reproductive Health

Reproductive Health
About Us +
Data and Statistics +
Emergency Preparedness and Response +
Maternal and Child Health Epidemiology Program +
Pregnancy Risk Assessment Monitoring System
Infertility +
Assisted Reproductive Technology (ART)
Depression Among Women +
Maternal and Infant Health -
Pregnancy Complications +
Diabetes During Pregnancy +

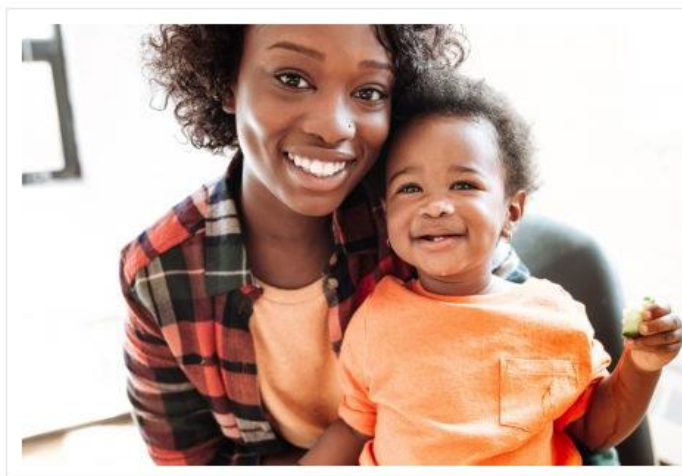
[CDC](#) > [Reproductive Health](#) > [Maternal and Infant Health](#) > [Perinatal Quality Collaboratives](#)

National Network of Perinatal Quality Collaboratives



CDC and the March of Dimes launched the National Network of Perinatal Quality Collaboratives (NNPQC) to support state-based perinatal quality collaboratives in making measureable improvements in statewide health care and health outcomes for mothers and babies. In 2017, CDC awarded the [National Institute for Children's Health Quality \(NICHQ\)](#) to serve as the coordinating center for the NNPQC. NICHQ will coordinate NNPQC activities, including providing support, mentoring, and resources for perinatal quality collaboratives (PQCs) to:

- Strengthen PQC leadership
- Identify and disseminate best practices for establishing and sustaining PQCs, and
- Identify and develop tools, training, and resources necessary to foster the sharing of best practices to support a sustainable PQC infrastructure.



Thank You

wgc0@cdc.gov

